IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 20, 2006

FILE COPY

Sheri Mellville
Pacific Cataract & Laser Institute
250 Bobwhite Court, Suite 100
Boise, ID 83706-7576

RE: Pacific Cataract & Laser Institute, provider #13C0001015

Dear Ms. Mellville:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, Pacific Cataract & Laser Institute, on August 24, 2006.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/mlw

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001015	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFIC CATARACT AND LASER INS	250 WEST BOBWHITE COURT, SUITE 100 BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS No deficiencies were cited during the Medicare re-certification survey of your Ambulatory Surgery Center. Pacific Cataract and Laser Institute is in compliance with 42 CFR Part 416, Conditions of Coverage for Ambulatory Surgery Centers. The surveyors conducting the Medicare certification survey were: Gary Guiles, R.N., H.F.S., Team Leader Penny Salow, R.N., H.F.S.	Q 000	FILE COPY	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.